ISSUE BRIEF
The Massachusetts Health Policy Forum

A Strategy for Healthy Aging in Massachusetts

Synthesis of Steering Committee Meetings and Progress

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Massachusetts as a Model for Healthy Aging

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Executive Summary

In 2009, the Tufts Health Plan Foundation launched a new strategic initiative for its grantmaking focused on Healthy Aging (HA) for older adults age 60-plus. Along with this new grant focus, the foundation has been working with the Massachusetts Health Policy Forum to leverage the foundation's grant-making efforts with policy and public education approaches aimed at building a HA movement in Massachusetts.

In December 2009, a conference was held in Boston with over 300 attendees, including policy experts, government officials, academic leaders, advocates and representatives of community-based organizations that work with older adults. The conference, *Healthy Aging in the Commonwealth: Pathways to Lifelong Wellness*, included speakers from the Massachusetts Executive Office of Elder Affairs, Department of Public Health, Commonwealth Care Alliance, Hebrew SeniorLife and a keynote by Nancy Whitelaw from the National Council on Aging. An issue brief authored by Walter Leutz at Brandeis University was released, outlining the essential components of HA, as well as policy and program approaches statewide and nationally.[1]

Since the conference, the Tufts Health Plan Foundation and Massachusetts Health Policy Forum formed a HA Steering Committee (SC) of key experts and leaders from government, academia, the provider community and grassroots organizations that work with older adults. This committee has met three times in March, May and June, 2010. The result was the identification and articulation of the focus areas for constructing an action plan for a broad state initiative on HA.

The SC discussions led to two important decisions: (1) to identify three priority **Program Elements** and four **Crosscutting Elements** for the HA strategy, and (2) to form subcommittees to work on plans to move forward on those elements. At the September 27th statewide conference in Boston, the leaders of the subcommittees will be announced and speakers will share their expertise on each of the three program elements. The conference will also offer opportunities for participants who are interested in getting involved in the planning process. The three program elements are:

1. Healthy Aging Programs: Build and maintain a statewide infrastructure of healthy aging programming for older adults.

2. Public Awareness: Improve public images of older adults in society and raise awareness of the benefits of active, healthy living among older adults.

3. Healthy Aging Communities: Launch pilot projects in select cities or towns that build HA into the fabric of communities by addressing environmental factors and coordinating with government as well as other community resources and organizations.

In addition, four other crosscutting elements have risen to the top as essential components of each of the above:

1. Older Adult Engagement: Engage older adults in all aspects of the HA strategy.

2. Evaluation: Build a research and evaluation infrastructure that demonstrates the value

[1] http://masshealthpolicyforum.brandeis.edu/publications/pdfs/Fall.Winter.2009/HealthyAging_IssueBrief_Web.pdf

of HA efforts.

3. Leadership: Create a structure to lead a broad, ongoing movement for HA.

4. Systems Linkages: Build bridges to companion services (e.g., health care, home care, long-term care, transportation, congregate housing, social and cultural groups).

This conference will highlight the three program elements of HA Programs, Public Awareness and Healthy Aging Communities. Following the conference, the three subcommittees will begin to formulate a comprehensive HA action plan, which lays out goals, milestones, roles, and resource strategies. Sign-up cards will be available for people who want to get involved in one of the subcommittees or in their community.

Background

The challenge in forming a strategy to promote Healthy Aging (HA) is to assimilate the broad and multi-dimensional aspects of HA into a focused and achievable initiative. A synthesis of the Steering Committee (SC) discussion on March 2, 2010 suggested a strategy with six mutually reinforcing elements related to: evidence-based HA programming, public awareness about HA, systems linkages, older adult engagement, evaluation, and leadership to promote the strategy.

At the meeting on May 5, 2010, the SC was asked to suggest specific actions and ideas for moving the HA Initiative forward in the short-, medium- and long-term. Participants wrote suggestions on sticky notes and posted them on corresponding sheets with each of the six elements. This was followed by discussion.

At the meeting on June 16, the SC added HA Communities as a priority program element and agreed to make Systems Linkages a crosscutting element. The SC also decided to create subcommittees to work on the three program elements.

This document is a synthesis of the discussions and decisions at the three SC meetings, with additions of some detail on the context of the initiative that were mentioned, but not detailed, in the meetings. These are included in the Overview and Context section that follows immediately below.

Finally, in reading the document, it is important to understand that it is a compilation of ideas rather than a consensus of the meetings or participants. During the meetings it was apparent that there are more ideas than can be included in the final initiative, and there are likely things that should be included in the plan that were not mentioned. In short, the "plan" needs additional work and refining, which is the role of the three subcommittees moving forward.

Overview and Context

The HA strategy for the Commonwealth needs to be as synergistic as possible with other systems and initiatives that are taking place. Based on our current scan, these include Executive initiatives in state government, federal stimulus funds received for the Chronic Disease Self-Management Program, and opportunities in the national health reform legislation.

Executive initiatives: On March 16, 2010, Governor Patrick and Secretary Hartstein announced a set of initiatives for older adults in the Commonwealth. The initiatives include maintenance of existing programs such as nutrition, Councils on Aging, and long-term supports and services in the community. They also include the new website (www.800AgeInfo) for explanations of aging issues and programming, as well as the Embrace Your Future campaign to encourage individual planning for financing long-term supports.

The initiatives are based on nine Principles for Aging Well and achieving the "best possible quality of life for all." The Principles include:

- positive concepts of aging,

- interdependence across generations and in communities,
- economic security,
- affordable and appropriate housing,
- managing one's own life,
- participating in the community,
- strong social assistance and support services,
- good transportation,
- meaningful caregiver support, and
- HA (defined as "sustain the best possible physical, cognitive, and mental health").

Thus, the HA Initiative is just one part of a broader context of policies and programming in the Commonwealth for older adults and their families. If the HA Initiative is to succeed, it should be embedded in and consistent with this broader vision. Fortunately, the concepts, goals, and programming of HA can meet this test. For example, the seven elements developed by the Steering Committee so far are synergistic with the principles put forward by the secretary and governor.

- HA Programs. The evidence-based HA programs have been proven to foster physical and mental health—one of the nine principles. Most also use an empowerment approach to learning, which is consistent with efforts to help older adults and their families take charge of other aspects of their lives.
- Public awareness. The HA movement pushes the envelope of positive images of older adults by showing that even those with chronic illnesses and disabilities can have vital lives and contribute in meaningful ways to their communities.
- HA Communities. Mobilizing HA initiatives at the community level is based on participation and working across generations. It can promote positive concepts on aging, and can cut across multiple areas such as housing, economic security, and support services.
- Systems Linkages. A successful HA Initiative will be built through bridges to companion services (e.g., health care, social and support services, transportation, congregate housing, and social and cultural groups). At the local level these services are interdependent with one another in creating aging-friendly communities, and they in turn work through interdependence with engaged older adults and their families.

- Older Adult Engagement. One of the core ingredients of HA is involvement in civic and community life, including involvement in efforts to create aging-friendly communities.

- Evaluation. Good policy and programming for older adults are built on showing what is working and what outcomes are achieved. A HA research and evaluation infrastructure can be part of this.

- Leadership. The HA Initiative needs strong and organized supporters and leaders, but they need to work in concert with other aging and related public health initiatives. This includes policy, administration, and operational approaches that use existing infrastructure whenever possible.

Stimulus funds for CDSM: A second piece of context is the $1.14 million federal stimulus grant the Commonwealth recently received to deliver the Chronic Disease Self Management program to 2,000 older adults in the next two years. Any HA plan that the SC develops needs to be consistent with, and hopefully reinforce, the state's approach for greatly expanding and sustaining CDSM offerings and enrollment. Several components to the state's plan are incorporated in the discussion below, including a new HA project manager position, a new contract to ensure fidelity, and a model to pay a unit rate per older adult who completes the CDSM class to organizations that deliver classes. This sets up some key pieces of infrastructure for eventually billing third parties for evidence-based (EB) programs.

Health reform opportunities: The national health reform legislation has a number of provisions that could increase medical system referrals to and payment for evidence-based HA programs. Most important regarding referrals is the new Medicare coverage of an annual wellness visit and the creation of a personalized prevention assessment and plan. Also important for referrals and possibly for reimbursement are a series of demonstration initiatives (medical home, team practices, accountable care organizations) that have the incentives and the means to include prevention in their practices.

Elements of a Healthy Aging Strategy

The remainder of this document reports on SC members' ideas and recommendations regarding the seven elements of a HA strategy. As noted in the Executive Summary, we have organized them into "program" and "cross-cutting" elements. Each section starts with a summary paragraph based on the SC's March 2, 2010 meeting and then presents recommendations/ideas. It also includes some ideas that might tie the HA Initiative more closely to state executive initiatives, the new CDSM grant, and health reform opportunities. After the discussion of the seven elements, an eighth section presents an idea for moving the plan forward through subcommittees for the three program elements.

Program Elements

1. Healthy Aging Programming

Summary: Under leadership from the Massachusetts Department of Public Health (DPH) and the Executive Office of Elder Affairs (EOEA), the Commonwealth is offering evidence-based HA

programs across the state in collaboration with a variety of community agencies. The challenge is to transform this into a permanent infrastructure of programming that is easily accessible, reaches all geographic areas and types of residential settings, remains state-of-the-art, and has the depth of programming that will keep older adults involved after taking evidence-based classes.

Steering Committee Recommendations: The SC recommendations included four elements: Assessment of the current system, diffusion of programming across the state, development of new curricula/courses, and how to finance and manage the system.

- System assessment: There should be a statewide mapping of all programs being offered, including EB programs and others, to identify areas of strength and weakness and geographic gaps. Two key questions are how many of the 300 CDSM trainers are still active, and what languages and cultural groups do they represent? The mapping could identify and recognize other activities, too, and assess how well integrated programming is. The map should be organized by region.

- Diffusion: There needs to be a policy goal regarding how often and how locally HA programs should be available to older adults (i.e. four times per year, within 10 miles) and then a plan for diffusing the required programming across the state. This will require trainers, settings for trainings, curricula to be offered, and a financing and organizational infrastructure for operations.

    - Master trainers and group leaders: Ideas for developing trainers included looking towards community health workers, aging services staff, university life-long learning programs, and older adults themselves. Attention needs to be paid to training to fill gaps by program, by geographic area, by language, and by culture. There is also a need to translate materials.

    - Community partners: It is essential to continue to recruit and involve community partners such as senior centers, health centers, senior housing, independent living, and faith groups. These groups bring the individual outreach that has proven effective in getting older adults to try and complete HA programs, and they also offer convenient settings for classes.

    - Infrastructure: The programs need to be offered in a cost-effective and sustainable manner. This suggests they should be embedded in existing programming infrastructure that meets key tests: statewide, good links to older adult referral sources, strong enough to organize classes and handle enrollment, capable of billing for classes or identifying other revenues, and capable of monitoring and ensuring fidelity. There are likely to be a variety of models for integration with health care and for community resources to ensure delivery systems, referrals and outcomes.

- Financing: One of the major long-term considerations to ensure the sustainability of these programs is developing funding sources. Recently, the state was awarded a two-year, $1.14 million grant for CDSM that is an important boost, but it will take more to build a sustainable system that ensures access to quality programs. In order to survive and expand in the long run, the evidence-based HA programs need reliable and stable funding. A logical source for

funding is Medicare, which should benefit financially when its beneficiaries complete EB programs, but there is no such coverage in Medicare. Nor are private insurers in general funding CDSMP, although many have care management programs for their own members. Perhaps the MA Initiative should help shape and encourage research that would spur revenue sources in the future. Financing is a policy initiative (see Leadership below), and having the infrastructure to offer high-quality services and pay for EB programs will require a financing mechanism.

- New curricula: There are currently several programs being offered in Massachusetts, including CDSMP, Healthy Eating and Matter of Balance. But, as discussed above, a new selection of programs is essential to keep older adults active once one program is complete. Examples of new programs include the five-week food security curriculum and Hebrew SeniorLife's COLLAGE program for individual assessments and individualized plans to help older adults reach their goals. Non-group strategies could also be considered, e.g., NCOA's internet-based CDSM at home.

2. Public Awareness

Summary: The concept of HA is not well understood by either older or younger adults, in part because of widespread ageism. Public awareness and education efforts should focus on positive images of older adults who contribute to their communities, who adapt to changing circumstances and abilities, and who take charge of their lives and their health. The first principle in the Commonwealth's aging initiative outlined above is to combat ageism as a goal: "Society understands the positive aspects of aging and recognizes the interdependence we rely upon to thrive. Modes to communicate this could include story boards, video biographies, and more. Public awareness also includes getting information to older adults about programs that support HA. The SC is very aware, however, that public relations and marketing campaigns—particularly ones that use electronic media—can be very expensive.

Steering Committee Recommendations: Overall, the initiative needs to draw the "big picture" of HA, as well as its details. What is the vision of HA for individuals and for communities? The recommendations from the SC included work on educating the public by honing the messages, creating a coordinated campaign, using a variety of media, and other approaches.

- Hone messages: There was some sentiment to hire a public relations consultant or firm to help hone messages, develop a marketing campaign, and create tools that can be used statewide and locally. One goal is to change the image of older adults from illness and disability to one focused on HA. Another goal is to hone messages of choice and responsibility, e.g., "better choices, better health," as well as intergenerational messages that target the broader 40-plus population. One idea was to use older star athletes and/or TV personalities as prominent spokespeople. In the long term there should be a continuous, but changing focus and a constant presence.

- Coordinate the campaign: The public awareness campaign should include a short-term and long-term plan, financing, placement strategies, compelling messages, and linkages to state programs. Public awareness and messages to change behavior toward HA also need to be

coordinated with programming and systems on the ground. Stand-alone messages are less likely to be effective than messages that can get reinforced with opportunities to take action and receive support from professionals and peers. Coordination should also include collaboration with other PR campaigns, e.g., Mass in Motion, a public health campaign to encourage improved nutrition and increased physical activity.

- Media: There were many ideas for media to be used.
    - Website - Point to the state's new www.800AgeInfo website, and the HA section on the site. Elders who use the internet are finding ways to stay connected that never existed before.
    - Print media - Create a column in the *Boston Globe* and other publications on "elder voices" where older adults speak on their needs and views.
    - Electronic - Create TV and radio ads showing healthy older adults and promoting the statewide HA effort.
    - Email - Agencies in the coalition could share email lists for mailings to older adults and supporters/collaborators.
    - Education - Strengthen gerontology/aging programs in schools and colleges.
    - Town/listening forums (see engagement).
    - Public displays - Create and distribute displays with literature and photos/videos of older adults and their lives for libraries, mall kiosks, and other settings (supermarkets, ADC, Senior Centers, houses of worship).
    - Start a HA Blog.
- Other: Healthy Aging Day, appoint a public commission on HA to study and make a report, older adults athletics events.

3. Healthy Aging Communities

Summary: The concept of the HA Communities program element stems from the socio-ecological model of individual and environmental change, i.e., individual behavior change is influenced by the environments in which individuals live, and the environment is in turn shaped by what individuals do. Therefore individuals are more likely to adopt and continue with healthy behaviors when they find support for those behaviors in their physical and social environments, and those environments are going to start to become "healthier" when individuals start to act in healthier ways, including working together to make social and environmental change. Moreover, the act of working toward change is consistent with the civic and social engagement aspects of HA.

Recommendations: The HA Communities element for core programming was added at the third SC meeting and as a result, it was not discussed in the same detail in the earlier brainstorming meetings of the SC. We do, however, have material from those meetings to flesh out the concept, and enough information in the literature to support some recommendations. These include:

° Involving individuals and organizations from multiple sectors in the discussions and planning, including government, service agencies, faith-based organizations, and people of all ages.

° Creating a participatory process for exploration and decision-making, which builds on the energy and interests that come forward.

° Considering both the social environment (e.g., services, socialization, civic engagement, volunteering) and physical environment (e.g., sidewalks, transportation, affordable healthy foods, etc.) as part of the planning.

° Developing pathways or blueprints for creating pilot demonstration projects in select cities or towns that build HA into the fabric of communities.

Following the successful model of obesity prevention in Somerville, there could be demonstration programs to show HA collaboration at the community level. Demonstrations could yield a "healthy aging communities blueprint," which could show how communities can choose various elements to include, e.g., good sidewalks to allow access, incentives to create/expand/convert buildings for affordability and accessibility and services, affordable and accessible housing and transportation, healthy restaurants, etc. Models for older adult involvement in leadership, planning and volunteering could also be demonstrated.

Crosscutting Elements

1. Older Adult Engagement

Summary: Older adults should be involved in all aspects of the HA strategy, including paid work, volunteering, outreach to isolated peers, advocacy, and research as well as developing the strategy and carrying out the plan. Professionals working on all fronts in the HA Initiative need to make special efforts to find ways for this involvement to be real and meaningful. Diversity by culture, race, ethnicity, sexual orientation, language, and class are also essential.

Steering Committee Recommendations: The SC recommendations focused primarily on finding more ways to involve older adults in participating in and shaping and informing the HA Initiative. Any such efforts should be careful to involve under-served communities and work to identify and address barriers to involvement for sub-groups. There were also recommendations concerning volunteering and work.

– Engagement in the HA Initiative: Several means of involvement were mentioned. The HA efforts could spur wider involvement of older adults in leadership in other regional and local environments—housing, neighborhoods, towns.

    ° Steering Committee - The SC and subcommittees should include older adults. One

idea was that each organization in the SC could recruit one to two elders as candidates. The reasons they are participating and any special expertise should be noted. Even if all cannot participate in the SC, they could be tapped as regional leaders or leaders for other elder engagement.

- Conferences/"Aging Summit" - Convene a multi-stakeholder summit on health and wellness with related workshops for engagement. Involve older adults in conference planning and action plan implementation.

- Focus groups/forums/listening sessions - Convene focus groups and/or forums around the state regarding needs and challenges and strategies.

- Community assessments - Create a process for assessment and planning that includes elders at the community level. Is this town/city supportive of HA? If so, how? If not, what to do?

- Work: More and more older adults are working, by both choice and financial necessity; and by working, older adults are contributing to the economy and often to their communities. Several approaches to successful work for older adults were suggested, including legislative and regulatory actions to promote greater workforce participation, increasing job training/ retraining programs for older workers, and promoting encore careers in nonprofits, e.g., aging, youth, schools, and the environment. The MA Partnership for Promoting Civic Engagement and Employment of Older Adults, as well as AARP, are among the groups engaged in this area. A conference on the older adult workforce to highlight benefits of hiring older adults would be one way to start the conversation.

- Volunteering: A variety of volunteering ideas were offered, including volunteering in schools to work with students and developing elder-to-elder support networks and "buddy" programs for meal preparation, shopping, driving, etc. Recruitment of volunteers could be through religious leaders, community leaders, and Councils on Aging.

2. Evaluation

Summary. In order for HA Initiative to survive and prosper, supporters will need to convince the public and policy makers that the initiative is making a difference. At least two areas of research and evaluation are needed. First, the fidelity and outcomes of evidence-based programs being offered in relation to the original models must be demonstrated. This will support the "business case" argument that the programs improve health and save more money in health care spending than they cost to deliver. Second, new definitions of the impact of HA on the quality of life for older adults and their families and communities need to be developed and measured. These latter impacts can be evaluated through community-based participatory action research (CBPAR) approaches that include older adults as co-researchers who help develop concepts, collect data, and interpret findings.

Steering Committee Recommendations: Recommendations from the SC regarding research and evaluation are ambitious. They include formation of an evaluation committee, supporting

agencies' participation in data collection and evaluation, ensuring the fidelity of EB programs, research on a broader model of HA, and dissemination of findings.

- Evaluation committee: An evaluation committee would serve several purposes, including:
    - Conducting an inventory of current research/evaluation in MA on HA.
    - Reviewing what has been learned from the implementation of the first three EB initiatives. It could look into broadening the curriculum by finding other best practices and exploring how to include them, e.g., healthy eating, healthy ideas, diabetes management.
    - Promoting CBPAR models, which would incorporate older adults into the research enterprise.
    - Challenging academic medical centers to take on HA.
    - Develop a logic model to take the SC's ideas to the next level. The model would anticipate outcomes and lead to a strategic/action plan.
- Support data and evaluation: Participating in data collection and evaluation should be an expectation, if not a requirement, for funding for HA program providers. Doing this will require the HA Initiative to define research goals, to link those goals to possible funding sources, and to obtain funding. To obtain high quality data, it will be important to provide technical assistance to community-based organizations.
- Ensure fidelity of evidence-based programs: In order for EB HA programs to achieve health outcome and cost savings results, they need to be implemented with fidelity to the tested models. To implement the new CDSM expansion, the Commonwealth intends to enter into a contract with a group to help monitor fidelity and create a repository of CDSM outcomes. A next step may be to engage Medicare, insurers and medical providers in discussions of the "business case" for the EB programs, including expected outcomes for each program and expected returns on investments.
- A broader model of HA: Another idea was that MA HA Initiatives could become living laboratories for older adult participants and staff. The HA Initiative should develop a credible and affordable evaluation model that fits with the plan. If the goal is improve quality of life, the model should include a new set of HA indicators that are not health specific, e.g., map family contacts, friendship networks, and faith-based connections.
- Dissemination and public reporting: Synthesize and share findings with the public. Praise and replicate successes; publicly eliminate or conclude failures with lessons learned.

3. Leadership

Summary. The core of state agency leadership, community agency involvement, and federal and foundation funding (including the Tufts Health Plan Foundation initiative) comprise a strong base

for implementing a broad HA strategy. The December, 2009 conference showed the depth and breadth of interest in HA in the Commonwealth, and the active involvement of the Steering Committee members since then is a promising sign. A structure for keeping these elements working together is needed to create a movement, expand political and financial support, and ensure success.

Steering Committee Recommendations: Recommendations from members of the SC regarding leadership for the HA Initiative included efforts in the political, policy and finance, and administrative areas, as well as work on refining the SC itself.

- Political: Several ideas for creating political support were discussed, including creating a legislative or governor's commission to continue HA work in the future, identifying a "public HA champion," enlisting an honorary chair and representatives from key organizations, and appointing a leadership coalition statewide to monitor progress and outcomes.

- Policy and finance: The HA Initiative needs to find ways to make itself sustainable within existing policy and funding structures. Coverage of EB programs through Medicare is one logical possibility, since Medicare potentially saves more in health expenditures than it would spend on EB programs that have fidelity to original models. To spur policy change, the HA Initiative could promote an evaluation plan to see if participation actually leads to long-term reductions in utilization and costs. This would need to include a process to set rates, define the service package, quality assurance and reporting, etc. In implementing the new federal CDSM funding program, the State has already set some of this in motion by establishing a process to ensure fidelity and by considering a model to pay a unit rate per completed participant to pay for CDSM programming.

- Steering Committee: SC members expressed wide agreement about the importance of keeping a SC together, both to shape the draft HA plan and the September Forum, and to create and maintain a sense of momentum. Questions for the SC include:

    - Besides older adults (see Older Adult Engagement), are there key stakeholders who are missing from the SC, e.g., institutional care providers, home health providers, other health care providers, the business community or representatives from other advocacy and nonprofit groups?

    - How will the HA Initiative be funded?

    - Are members ready to "take the plunge" to declare the SC as complete in terms of membership, and as a leadership structure and to develop a public presence? One ingredient for doing this might be to create a memorandum of understanding/ endorsement process for organizations to support in joining.

    - Should there be a survey of the SC, with questions regarding: What do you hope to get out of the efforts?

    - How should the SC be structured? Subcommittees for each of the key program elements have now been established.

- Management and administration: The HA Initiative needs a clear and functional administrative and management structure, as well as clear divisions of labor, for bringing HA programs to older adults and for promoting the other elements (elder involvement, linkage, public awareness, and evaluation). The EOEA/DPH leadership team has already put in place several key components for implementing the CDSM expansion, which can be used as models and infrastructure for other parts of the HA Initiative. These include:

    - Creation of a position for a CDSM project manager.

    - A process to ensure fidelity to the original CDSM program.

    - Consideration of a unit rate to pay providers of CDSM classes, which could underpin a way for the aging network and others to offer, enroll, and bill for the work involved.

    - Formation of regional approaches

Crosscutting Element 4: Systems Linkages

Summary: The widely accepted public health "socio-ecological" model posits that individuals are most likely to adopt "healthy" behaviors when their environment supports such behaviors (and vice versa). Therefore support from key systems in the environment is important (e.g., accessible transportation and walk-able communities, healthy food alternatives, health and home care providers that encourage participation in HA programs). While it may be unrealistic for the HA Initiative to transform these companion systems and services, it is realistic to establish linkages and communication with them to begin to gain their cooperation and support, e.g., referrals from physicians to evidence-based programs, better connections to more transportation options for older adults.

Steering Committee Recommendations: The SC recommendations included working to change policy to promote linkages, tying HA into changes created by health reform in the medical care delivery system and benefits, and promoting models for collaboration at the community level.

- Improve policy: Service provision, reimbursement, and policy making tend to focus on discrete sectors, e.g., private, Medicare and Medicaid insurance; long-term supportive services in the home and community; housing; transportation; nutrition. Several SC members suggested bringing together top leadership of these sectors in a summit meeting to address how to better link services and payment for individuals they all serve. One suggestion was to give grants and funding based on collaboration.

- Tie HA into health care delivery reforms: The national health reform bill contains several provisions that could increase referrals from medical care providers to EB programs, and perhaps even support payment for the programs. Most important is that Medicare will soon cover, with no co-payment or deductible, an annual wellness visit and the creation of a personalized prevention assessment and plan. Prevention services include referrals to education and preventive counseling or community-based interventions to address risk factors. The HA Initiative should try to get EB HA classes into the planning and referral processes for

major health care providers in the Commonwealth, for example, by providing information packets for providers to incorporate into prevention/wellness plans. Other provisions will promote a variety of team-based care provision focused on high-risk patients, mostly through demonstration programs.[2] If any of these demonstrations are mounted in the Commonwealth, it will make sense to ask them to include prevention and evidence-based empowerment programs in these practices. To the extent that medical payments are bundled and pre-paid, teams may be willing to pay for HA classes.

Subcommittee Structure, Responsibilities, and Participation

Overview: As the Tufts Health Plan Foundation and Massachusetts Health Policy Forum, with input from the Steering Committee, moved forward to organize the September 27th Forum in Boston, subcommittees were formed to address the three key Program Elements:

- ► Healthy Aging Programs
- ► Public Awareness
- ► Healthy Aging Communities

The three subcommittees are charged with developing plans for strengthening HA programming in their respective areas. The plans should take into account the current work by state and local government, providers, advocates, and others in their areas, as well as the interfaces of efforts in the other subcommittee areas. The goal is not to "re-create the wheel" but rather to see if and how existing initiatives, participants, and resources can be better coordinated and mobilized and if new partners and resources can be enlisted to work toward common goals.

The committees will take into consideration the four cross-cutting elements in formulating their plans:

- ► Older Adult Engagement: In what ways is the plan engaging older adults in the process as well as project implementation?
- ► Evaluation: In what ways does the plan measure the effectiveness and ultimate impact of these programs?

[2] Under other sections, H.R. 3590 will:

- create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their homes and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction.
- allow groups of providers who voluntarily meet certain criteria to work together to manage and coordinate care for Medicare fee-for-service beneficiaries through Accountable Care Organizations (ACOs) under Medicare. ACOs that meet quality performance standards are eligible to receive payments for shared savings if costs are a certain percentage below a benchmark.
- create a new Medicaid state plan option under which Medicaid enrollees with chronic conditions (including a mental health condition, substance use disorder, asthma, diabetes, heart disease, or weight problem) can designate a provider, team of health care professionals, or a health team as their health home.
- establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional teams to support primary care practices.

(Source: Gerontological Society of America website, March 2010)

- ► Leadership: Who is going to lead the effort going forward/who is responsible for various aspects of the plan?

- ► Systems Linkages: In what ways does the plan involve government and organizational entities and the services they provide for older adults? In what ways does the plan incorporate ideas/plans from the other two focus areas?

Additionally, all project plans must be:

- ► Politically feasible

- ► Financially feasible

- ► Sustainable

The Subcommittees: This section summarizes the charters of the three subcommittees. At the Forum, there will be signup cards for participants to indicate interest in getting more information about the subcommittees.

1. Healthy Aging Programs Subcommittee

The HA Programs Subcommittee is charged with developing a plan for building and sustaining HA programs in Massachusetts. To achieve this aim, the charge of this committee is to develop a plan to:

- Disseminate evidence-based and other HA programs statewide.

- Increase outreach for programs to particularly vulnerable populations, including low-income, ethnic and racial minorities, non-English-speaking, and lesbian, gay, bisexual and transgender older adults.

- Sustain funding for evidence-based and other HA programs.

Ensure fidelity in terms of programs and evaluation/data collection, as programs grow in number and geographic reach.

2. Public Awareness Subcommittee

The Public Awareness Subcommittee is charged with developing a plan for improving public images of older adults in society and raising awareness of the benefits of active, healthy living among older adults, thereby leading to (1) older adults being more physically, socially and civically active and (2) greater societal support for HA programs and a more positive perception of older adults in general. To this aim, the charge of this committee is to develop a plan that

healthy foods, etc.) and coordinating with government as well as other community resources and organizations to develop a blueprint for what it means to age healthily in a community setting. To this aim, the charge of this committee is to develop a plan to:

- Build a blueprint for a community that supports HA.
- Create a plan by which cities and or towns would be selected to pilot this concept.
- Include a list of partner government entities, businesses and nonprofit organizations to be involved in carrying out the project.

Moving forward, the subcommittees with work with the Steering Committee over the course of the next few months with the goal of completing an action plan by the end of 2011.

APPENDIX A
HEALTHY AGING STEERING COMMITTEE

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